Good Samaritan Ministries (GSM)
Request for Counseling Form 501 (c)(3)

Date: _____

Name: _____
(***Please print***) First Name Middle Initial Last Name (s)

Date of Birth: _____ **Birth Place**:_____ **Age**_____ **Gender:** ☐ M ☐ F

Address: _____ City _____ State_____ Zip_____

Phone: (Home) _____ (Cell) _____ (Work) _____

Okay to leave a message on <u>Home</u> phone? ☐*yes* ☐*no* <u>Cell</u> phone? ☐*yes* ☐*no* <u>Work</u> phone? ☐*yes* ☐*no*

Contact you by <u>mail</u> at your home address? ☐*yes* ☐*no* Appt Reminder by e-mail? ☐*yes* ☐*no*

E-mail: _____ <u>Interested in Monthly GSM Email Update?</u> ☐***yes*** ☐***no***

<u>In case of emergency, please notify: (someone not living at your residence)</u> **:**

Name: _____ Relationship to you: _____

Address: _____ City _____ State _____ Zip _____

Phone: (Home) _____ (Cell)_____ (Work) _____

Marital status: □ Married □ Separated □ Divorced □ Partnered □ Never Married □ Single □ Widowed

Names and ages of children: _____

<u>Have you met with a GSM counselor previously?</u>____<u>When?</u>_____<u>Name of Counselor</u>_____

Referred By: _____

If **not referred**, how did you learn about Good Samaritan Ministries? ☐ Friend ☐ Relative ☐ Internet ☐ At event sponsored by GSM ☐ Other _____

Please indicate **day** (M-F) of week and **time of day** that you are available for counseling appointments. Check **<u>all</u>** that apply: (note – The more boxes you check, the sooner we can place you.)

DAY OF WEEK	MORNING	AFTERNOON	EVENING
Monday	☐ 8 AM-noon	☐ Noon-5:00 PM	☐ 5-9:00 PM
Tuesday	☐ 8 AM-noon	☐ Noon-5:00 PM	☐ 5-9:00 PM
Wednesday	☐ 8 AM-noon	☐ Noon-5:00 PM	☐ 5-9:00 PM
Thursday	☐ 8 AM-noon	☐ Noon-5:00 PM	☐ 5-9:00 PM
***Friday**	☐ 8 AM-noon	☐ Noon-5:00 PM	***Closed by 5:00 PM**
Saturday	☐ 8 AM-noon	☐ Noon-5:00 PM	☐ 5-9:00 PM

GSM makes every effort to schedule counseling to accommodate client availability.

What type of counseling are you seeking: ☐ **Individual** ☐ **Adolescent** ☐ **Child** ☐ **Family** ☐ **Couples** ☐ **Addiction** ☐ **Court-ordered** ☐ **Relationship** ☐ **Grief** ☐ **Other:** _____

Signature _____

(office) Date received: _____

<u>Please</u> <u>RETURN COMPLETED PAPERWORK TO:</u>

Good Samaritan Ministries Email: frontdesk@gsmusa.org
7929 SW Cirrus Dr. #23
Beaverton, OR 97008 FAX: (503) 646-8898 Phone: (503) 644-2339
www.GoodSamaritanMinistries.org

Good Samaritan MINISTRIES

CLIENT RIGHTS AND RESPONSIBILITIES

As a client of GSM, you are entitled to:

- Be treated with respect and dignity;
- Receive services without regard to race, culture, language, religion, gender, age, national origin, disability, creed, marital status or sexual orientation;
- Confidentiality: Information you share with the staff of this agency will be held in confidence within this agency. Information about you will not be released to outside individuals, agencies, or institutions without your written permission except under the following circumstances: certain situations of threat or harm to yourself or others; medical emergencies; abuse of a child, elderly person or certain disabled individuals; or, if there is a court order to release information, or if other conditions exist that would permit unauthorized release of information as allowed by statute or law;
- Consent to treatment and refuse services. All clients have the right to refuse treatment or any specific service or procedure. Consent for treatment will be documented on the client's initial authorization for treatment as well as on their treatment plan and all subsequent updates as they agree to the plan. If your refusal of services or any specific procedure will result in termination from services or referral to court or other supervisory authority, you will be informed verbally and in writing;
- Lodge a grievance or complaint if you have reason to believe your rights have been violated;
- Receive written notification of any denial or reduction of service which you do not agree with, and explanation of the action;
- Review your clinical record, and obtain a copy of it within five business days of requesting it. You may be charged duplicate costs. There are exceptions to this right: you may be denied access to your record if you have been declared legally incapacitated, in which case your legal guardian can request a viewing of your record, or if the disclosure of your record would be seriously detrimental to your treatment;
- Informed participation in the planning and receipt of services and to review your progress toward your goals and objectives related to your contact with this agency;
- Freedom from physical, sexual or emotional abuse or exploitation;
- The right to request a different GSM staff provider;

As a client of GSM, we ask that you be responsible to:

- Treat staff and other clients with dignity and respect;
- Refrain from illegal activities on GSM property;
- Respect the physical safety of other clients and GSM staff;
- Actively engage in the counseling process; be open and honest to the best of your ability;
- Follow recommendations to the best of your ability and discuss any disagreements with your therapist;
- Inform your therapist if you use alcohol or unprescribed drugs that may interfere with your progress or goals, and be willing to obtain help if recommended;
- Attend all scheduled appointments or cancel appointments at least 24 hours in advance if unable to attend. If frequent canceling or missing of appointments occurs, any of the following may happen:
  1. Therapist may discuss with you a different frequency of appointments;
  2. Therapist may reduce or discontinue appointments for a specified period of time;
  3. Therapist may discontinue appointments.